Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NORTHWEST TEXAS HOSPITAL
3255 WEST PIONEER PARKWAY
ARLINGTON TX 76013

Respondent Name

TPCIGA FOR PROVIDENCE PROPERTY

Carrier's Austin Representative Box

Box Number 50

MFDR Tracking Number

M4-07-6913-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HRA has been hired by Northwest Texas Hospital to audit their Workers Compensation claims. We have found in this audit you have not paid the appropriate reimbursement according to the Acute Care Inpatient Hospital Fee Guideline. Per the ACIHFG, claims with charges over $40,000 are to be payable at 75% of charges." "This would mean, the charges should be recognized as over the stoploss threshold and processed at 75% of charges."

Amount in Dispute: $144,726.18

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The above admission is subject to reimbursement pursuant to Rule 134.401(c)(5). Reimbursement for the entire admission was based on a fair, reasonable and consistent methodology neither the per diem nor the stop loss method applies to the admission." "Northwest Texas healthcare System is requesting payment for this admission based on Stop Loss Formula 75% of charges. The principle diagnosis code was 801.25 related to trauma care for closed skull base fracture. Pursuant to Rule 134.401(c)(5), this admission was recommend for payment based on fair, reasonable and consistent methodology which includes reimbursement for like admissions by CMS (Medicare), Usually and Customary Data and other benchmarks."

Response Submitted by: Providence, 4760 Preston Rd #244, Frisco, TX 75034

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 29, 2006 Through September 9, 2006	Inpatient Services	$144,726.18	$0.00
August 30, 2006	CPT Code 93010		

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.202, effective August 1, 2003 sets out the reimbursement guideline for professional medical services**.**
3. 28 Texas Administrative Code §134.401(c)(5)(A), effective August 1, 1997, 22 *Texas Register* 6264, requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate.
4. 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
5. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
6. This request for medical fee dispute resolution was received by the Division on June 19, 2007.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of Benefits (EOBs) dated October 12, 2006 for CPT code 93010 rendered on August 30, 2006

   - 100-Any Network reduction is in accordance with the Network referenced above.
   - 113-001-Network import re-pricing – Contracted Provider.
   - 663-Reimbursement has been calculated according to state fee schedule guidelines.

   Explanation of Benefits dated October 25, 2006 for inpatient services

   - W1 (28) – RC 28 The reduction was made for reasons indicated in note below or on the attached note or letter.
   - W1 (JF) – RC JF Documentation submitted does not substantiate the service billed.
   - W1 (RD) – RC RD The reimbursement for the service rendered has been determined to be fair and reasonable based on billing and payment research, and is in accordance with labor code 413.011(b).

   Explanation of Benefits dated April 4, 2007 for inpatient services

   - W1 (YO) – RC YO Denial after reconsideration.
   - W1 (YS) – RC YS Supplemental Payment.

Findings

1. The requestor included in this dispute a bill from Dr. Sammy Cox for CPT code 93010 – Electrocardiogram report done on August 30, 2006. The requestor billed $22.00 and was paid $10.50 based upon EOBs reduction code "100," "113-001," and "663." A review of the bill indicates that both the requestor, Northwest Texas Healthcare System and Dr. Cox have the same Federal Tax Identification Number 232238976. A review of Box 32 of the CMS-1500 indicates that the services were rendered at Northwest Texas Healthcare System. Furthermore, Box 33 of the CMS-1500 indicates that the physician's supplier's billing name is Northwest TX Hosp Readers.

   The Division finds that the documentation does not include any letter of representation from Dr. Cox that the

requestor may pursue medical dispute resolution on these charges on his/her behalf. Therefore, the Division will not consider these charges further in this decision.

2. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 801.25. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
3. The requestor asks for reimbursement under the stop loss provision of the Division's *Acute Care Inpatient Hospital Fee Guideline* found in Division rule at 28 TAC §134.401(c)(6). The requestor asserts in the position statement that "HRA has been hired by Northwest Texas Hospital to audit their Workers Compensation claims. We have found in this audit you have not paid the appropriate reimbursement according to the Acute Care Inpatient Hospital Fee Guideline. Per the ACIHFG, claims with charges over $40,000 are to be payable at 75% of charges." "This would mean, the charges should be recognized as over the stoploss threshold and processed at 75% of charges." Division rule at 28 TAC §134.401(c)(6), effective August 1, 1997, 22 TexReg 6264, states, in part, that "The diagnosis codes specified in paragraph (5) of this subsection are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate." As stated above, the Division has found that the primary diagnosis is a code specified in Division rule at 28 TAC §134.401(c)(5); therefore, the disputed services are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 TAC §134.1
4. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:

   - The requestor's position statement asserts that "HRA has been hired by Northwest Texas Hospital to audit their Workers Compensation claims. We have found in this audit you have not paid the appropriate reimbursement according to the Acute Care Inpatient Hospital Fee Guideline. Per the ACIHFG, claims with charges over $40,000 are to be payable at 75% of charges." "This would mean, the charges should be recognized as over the stoploss threshold and processed at 75% of charges."
   - The requestor seeks reimbursement for this admission based upon the stop-loss reimbursement methodology which is not applicable per 28 Texas Administrative Code §134.401(c)(6).
   - The Division has previously found that a reimbursement methodology based upon payment of a percentage of a hospital's billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, which states at 22 *Texas Register* 6276 that:

     "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."

     Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		1/20/2012
Signature	Medical Fee Dispute Resolution Officer	Date
		1/20/2012
Signature	Health Care Business Management Director	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.